California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
April 25, 2008

The meeting was called to order by Vito Genna, Chair, at approximately 9:30 a.m., at the 400 R Street, Sacramento. A quorum of the members was in attendance.

Present: **Absent:**

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Sonia Moseley
Jerry Royer, MD, MBA
Adama Iwu
Corinne Sanchez, Esq.
Reza Karkia, DBA
Joe Corless, MD, FAAP

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Bob David, Chief Deputy Director; Beth Herse, Senior Staff Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Patrick Sullivan, Assistant Director, Legislative and Public Affairs; Joseph Parker, PhD, Director of Healthcare Outcomes Center; Jonathan Teague, Manager, Healthcare Information Resource Center; Candace Diamond, Manager, Patient Discharge Data Section; Starla Ledbetter, Data Management Office; Linda Janssen, Manager, Healthcare Information Resource Center

Others Present: Pamela Lane, Vice President, Health Informatics, Chief, California Hospital Association; Laurie Chisolm, UCLA; Marnie Granados, UCLA; Niambi Kingory, UCLA

Swearing in of New Commissioners: David M. Carlisle, MD, PhD, Director, OSHPD

Director Carlisle administered the oath of office to the two new Commissioners, Reza Karkia, and Joe Corless. Commissioner Karkia has served on the California

Council on Criminal Justice for the past 11 years and is newly appointed by Governor Schwarzenegger to represent the general public on the California Health Policy and Data Advisory Commission (CHPDAC). Commissioner Corless is a pediatric allergist working for the San Bernardino County Hospital and is also newly appointed by Governor Schwarzenegger to represent the general public on the CHPDAC.

Chairperson's Report: Vito Genna, Chair

Chairperson Genna welcomed the new Commissioners and gave several brief remarks explaining the structure of the three committees that report to the CHPDAC.

The Health Data and Public Information Committee, HDPIC, balances the need for data, the cost factor for hospitals, and the information consumers need. The HDPIC is currently Chaired by Marjorie Fine, MD.

The Technical Advisory Committee, TAC, works on risk-adjusted outcome studies. Statutory requirements dictate the composition of the Committee insuring that providers, consumers and researchers are represented. The Technical Advisory Committee is currently Chaired by Jerry Royer, MD.

The Appeals Committee handles appeals from healthcare providers that have not submitted their information by the current deadline and have incurred a one hundred dollar a day fine. The Appeals Committee has not met recently and Chairperson Genna cited this as a positive indication of how well the Office is working with the healthcare providers. The Appeals Committee is currently Chaired by Corinne Sanchez, Esq.

Approval of Minutes: A motion was made by Commissioner Sanchez and seconded by Commissioner Greenfield to approve the minutes of the February 15, 2008 meeting. The motion was carried.

The Commission agreed to reschedule the December 5, 2008 CHPDAC meeting to December 12, 2008.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

Director Carlisle welcomed the Commission to the Office's new location at 400 R Street. Currently OSHPD has completed phase one of a two phase move that will see all the Sacramento staff consolidated within this new location. Phase two should be completed by late October or early November. The Los Angeles component of the Facilities Division will remain at separate geographical location.

Director Carlisle announced that Deputy Director Michael Rodrian would be retiring at the end of May. During his tenure with the Healthcare Information Division, he has had a significant impact on the operations. Director Carlisle stated that he wanted to express his appreciation for his great leadership, as well.

The California budget crisis has been discussed at previous meetings and continues to be dire. Recent information indicates that revenues continue to fall and there is no

evidence of a leveling or upturn of revenues for the State. There have been discussions on the Democratic side of the legislature about requiring tax increases revenues.

The budget crisis represents a significant moment in California history and there will undoubtedly be some major changes to many programs to help achieve some revenue neutrality for the State. This means the Governor has some very difficult decisions to make and he remains cognizant of the impact that these cuts will have on individual welfare, healthcare, and public safety in the State of California.

OSHPD is primarily a Special Fund supported department and as such is not as sensitive to the General Fund crisis as other departments. Nevertheless budget hearings have already occurred which have included discussions on using some of our Special Funds to support a portion of the General Fund cuts. This will specifically impact OSHPD's Song-Brown program which supports family medicine trainees, nursing medicine, and physician assistants throughout the State.

Legislative Update: Patrick Sullivan, Assistant Director, Legislative and Public Affairs

There have been three significant changes in the leadership roles in the Legislature since the last Commission meeting. In the Senate, Senator Dave Cogdill will replace the Senator Dick Ackerman, and at the end of this year, Senator Darrell Steinberg will replace Senate President pro Tem Don Perata. In the Assembly, Assemblymember Karen Bass will replace Assembly Speaker Fabian Nunez. These changes follow directly on the failure of the term limit initiative.

The Legislature passed their first policy deadline which call for bills to be through the Appropriations Committee by mid-May and out of their house of origin by the end of May.

There are a number of bills that the Office is currently looking at because they would directly impact the Office.

AB 2966, by Assemblymember Lieber, is sponsored by the Professional Engineers in California Government and has the largest impact on OSHPD. This bill would require that OSHPD become responsible for the employment of hospital inspector records. Inspectors help OSHPD staff monitor and make sure that hospitals are built according to plan. This bill is moving through the Appropriations Committee.

AB 3028, by Assemblymember Salas, is sponsored by OSHPD. This bill would help OSHPD's Facility Development Division streamline and improve its plan review process by way of improving our electronic review and initiating the use of new technologies.

AB 2375, by Assemblymember Hernandez, is sponsored by the Latino Coalition for a Healthy California. This bill would establish as Health Professions Workforce Task Force to develop a Health Professions Workforce Master Plan for the State. The goal is to outlay a master plan on how California can address workforce issues by bringing in both public and private entities.

AB 2942, by Assemblymember Ma, is sponsored by the Service Employees International Union (SEIU). This bill would overhaul and standardize the community benefit reporting. Currently, nonprofit hospitals have to provide OSHPD with their community benefits reports and OSHPD houses the information. This bill would require that both private and nonprofit hospitals provide community benefits reports to OSHPD and that the information be made available on the OSHPD website.

AB 2967, by Assemblymember Lieber, is sponsored by SEIU. This bill would establish a Healthcare Cost and Quality Transparency Committee at the Agency level. This Committee would develop and recommend a health care cost and quality transparency plan to the Secretary of Health and Human Services. This has a significant impact on OSHPD because it would require the use of many OSHPD services and data. At present the CHPDAC is not specifically mentioned in the bill.

AB 2439, sponsored by De La Torre, would require the Medical Board to collect a mandatory $50 fee from physicians and surgeons at the time of licensure or biennial renewal to support the Steven M. Thompson Physician Corps Loan Repayment Program. It would also require 15 percent of the funds collected from the additional $50 fee to be dedicated to loan assistance for physicians who agree to practice in geriatric care settings. Currently, the Stephen M. Thompson program is without a funding source, relying on voluntary contributions from physicians. Eighty to one hundred thousand dollars is collected through the voluntary contributions, and the new mandatory fee would significantly increase that amount.

AB 2543, sponsored by Assemblymember Berg, would establish the Geriatric and Gerontology Workforce Expansion Act and establish three new programs to increase the number of students trained in geriatrics or gerontology and to repay qualifying educational loans of registered nurses (RNs), social workers (SWs) and marriage and family therapists (MFTs) who practice in or agree to practice in geriatrics or gerontology.

SB1379, by Senator Ducheny, is sponsored by the California Medical Association. This bill addresses the funding issue pertaining to the Stephen M. Thompson program by diverting the fines and penalties assessed on healthcare plans, which currently go to the Department of Managed Healthcare, to the Stephen M. Thompson program. This bill has left the Policy Committee and moved into the Senate Appropriations Committee.

SB 1271, by Senator Cox, is sponsored by OSHPD. This bill would increase the small project cap, from OSHPD's Cal-Mortgage program, from 5 million dollars to 10 million dollars, making it easier for smaller projects to gain access to capital.

AB 524 Technical Advisory Committee Report: Jerry Royer, MD, Chair

Commissioner Royer gave a brief summary of the presentations from the April AB 524 Technical Advisory Committee (TAC) meeting which included the following:

- Possible additions to the patient-level data sets
- Discussion of Percutaneous Coronary Interventions (PCI) in California pursuant to CHPDAC request that the Office consider studying PCI outcomes

- Congestive Heart Failure (CHF)
- Patient Discharge Data (PDD) Validation Study

There was a long discussion at the TAC meeting pertaining to percutaneous coronary interventions (PCIs). It was noted Director Parker's presentation at the April TAC that coronary artery by-pass graft surgery in California has dropped, over the years 1997-2006, from 28,000 to 15,000, while PCIs have increased from 45,000 to 60,000. The mortality is close, with 1.8 for CABGs and 1.5 for PCIs. After a lengthy discussion about what these numbers mean, the TAC has sent a recommendation forward to the CHPDAC that OSHPD look at PCI outcomes reporting in terms of appropriateness of the interventions. "There is substantial literature indicating that about 20 to 30 percent of these procedures, as well as CABGs, are inappropriate. The sense was that if we want to make a change in California, in this area, that we would want to look at appropriateness instead of an outcomes report."

Commissioner Fine asked if CHPDAC has ever done a feasibility report on whether a procedure is appropriate. Commissioner Royer replied that to his knowledge there have not been any appropriateness studies done.

Commissioner Fine stated that it is very difficult to even arrive at agreements on definitions for new data elements, "I can't imagine how much expert conflict you would get in trying to determine appropriateness of percutaneous interventions.

Chairperson Genna stated that, to clarify for the new Commissioners, "at the last Commission meeting, the motion from the Commissioners was that the Office go forward on seeing the possibility of a PCI outcomes study." The TAC took a different direction when they recommended looking at an appropriateness study. "This direction is very foreign to the studies that we've done in the past."

Commissioner Brien stated that he was in agreement with Commissioner Fine with respect to doing an appropriateness study. "I am not sure that we have evidence-based medicine to look at the parameters of what creates the appropriate indications for PCI. You put a group of cardiothoracic surgeons in the room with the cardiologist, and they will have very different indications for doing stents versus going directly to coronary bypass grafts." Another component of the appropriateness study is that the technologies improve. "I think we will be chasing ourselves for years and once we get the data, we are not going to know what it means because the whole technology potentially may have changed; the indications at that point may have changed."

Commissioner Fine stated that she would strongly recommend that the Commission vote down this recommendation. "If we need anything, we need an outcomes result that we can look at and see where that leads us."

Director Carlisle stated that "to add some additional context to the discussion, probably where we are with percutaneous intervention procedures is where we were 15 years ago with CABG, when we were just starting to conceptualize how we might want to move forward. I would also say that it is our assessment that to do an appropriate outcomes study for PCI would require legislative statutory authority. So it is probably not within the

purview of the Office or the Commission to definitively say whether we should move forward or not. Such a step is really dependent upon legislative action, and the legislative action is probably going to guide us in how we may want to move forward."

Commissioner Royer asked the Commission for a show of hands in voting as to whether the recommendation be sent to the Department that "we look at the feasibility of appropriateness studies for PCI." All were opposed except for Commissioner Moseley who abstained. The recommendation was voted down.

Commissioner Greenfield made a motion to "recommend that we pursue looking at an outcome studies on PCIs."

Commissioner Brien stated that he would be in favor of "having the staff go through the process of looking at whatever work flow, which may include looking at current administrative data, seeing what shows up, as part of any basic groundwork for what may be an outcome study. I would look to Dr. Carlisle and the staff to recommend whether or not it needs legislative approval to go forward and expand it. And then come back to the Commission with the recommendation as to whether we go forward with this or not. I think you have to start looking at the basic data elements that we have, looking at other studies and other State and Federal organizations that are doing this data, looking at risk-adjustment assessments, and then deciding whether we move forward with a full-on outcomes data report. I think this is a great opportunity for us to look at this."

Director Carlisle stated that "I feel confident that the motion, as stated, really gives us the direction to move in. As stated, we feel that we would have the support of the CHPDAC to further explore this area."

Chairperson Genna called for a vote on the motion to ask the Office to look at a PCI outcomes study. The motion passed with a unanimous vote.

The second recommendation to come out of the April TAC meeting was "that the Office proceeds with congestive heart failure as a new risk-adjusted outcomes report." At the TAC meeting there was no disagreement on proceeding.

Commissioner Royer moved that the Office proceed with congestive heart failure as a new risk-adjusted outcomes report. Both Commissioner Fine and Commissioner Greenfield seconded. The motion passed with a unanimous vote.

Commissioner Greenfield asked Deputy Director Rodrian if there was any current legislation regarding methicillin-resistance?

Deputy Director Rodrian stated that the Office was not tracking any specific bill on methicillin-resistant staph aureus (MRSA), but there have been several bills and a lot of discussion on in this area. "The lead agency on that, at present, is the Department of Public Health, specifically in the licensing and patient safety area.

Commissioner Greenfield followed up by asking, “So could they hand it over to us to be the data collecting point for that information?”

Director Carlisle stated that this issue is more of a public health issue at this time.

Chairperson Genna added that at the last meeting there was a speaker who proposed that we collect tracking information on MRSA, especially facility specific. There will be a report on this at a CHPDAC meeting later this year.

Summary Report on suggestions received from facilities regarding definitions of possible new patient-level data elements: Starla Ledbetter, Data Projects Manager

Manager Ledbetter stated that at the last meeting she had talked about a survey that was going to be sent to 458 hospitals regarding the proposed clinical data elements. The survey is still open through May 2nd, but the Office has some results to report from the surveys that have been returned.

Preliminary results:

- For operating physician ID, 75 percent of the hospitals that responded collect the physician name, as well as an in-house number. In addition, 50 percent of those facilities collect the license number and the national provider ID.
- For patient address, all the hospitals have responded that they collect the primary address and 72 percent collect what is called the secondary address, which is the apartment number or suite number. In addition, 70 percent collect the name of the country, for countries outside of the United States.
- For lab values, 90 percent of the hospitals reporting at this point agree with OSHPD’s proposed definitions, and approximately 80 percent agreed with OSHPD’s proposed format for reporting the individual values.
    - 80 percent of the facilities report using conventional units rather than international units. 43 percent of the facilities reporting at this point state that they can extract the lab values and electronically append them to the OSHPD discharge data file.
- For vital signs, over 95 percent of the hospitals responding agreed with OSHPD’s proposed definitions, the reporting units and the formats.
- For time of admission, most hospitals define the time of admission as the admission order or the time of registration.

The survey also asked the name of the hospital that patients are transferred from and transferred to. The results showed that 75 percent of the hospitals reporting capture the name of the facility the patient was transferred from and 84 percent capture the name of the facility the patient is transferred to.

In the category of electronic health record (EHR), 80 percent report the target date for the implementation of their EHR is unknown at this time, and 16 percent report the implementation will occur between 2009 and 2012.

As for the lead time the hospitals would like before implementing any of these changes, 44 percent of the hospitals would like at least a one year notice, and nine percent would like two or more years notice.

Hospitals were asked how they felt about either implementing all the proposed data elements at once, or phasing them in over time as groups of data elements. 63 percent of the hospitals responding stated they would prefer having the data elements phased in over time.

Commissioner Karkia asked how this is related to reducing the health care costs in the State of California.

Director Parker answered that "the idea behind most of these data elements is providing more information about quality. You have more clinical data to enable better risk adjustment, so your quality measures are more refined, and they also have greater clinical-based validity with the provider community."

Commissioner Karkia asked then "if a facility or hospital does not comply, or is not any where close to the quality that we are trying to establish, is there any enforcement with which we can make them?"

Deputy Director Rodrian answered that there are two ways. One is the marketplace. "There is the marketplace repercussion when you don't provide quality of care and that becomes clear. The other area of enforcement, if things were very egregious, would be the purview of the Licensing and Certification Division of the Department of Public Health."

Report on Updating OSHPD's 2004 "Preventable Hospitalizations in California" and OSHPD's 2003 "Racial and Ethnic Disparities in California" Reports: Jonathan Teague, Manager, HIRC

Manager Teague gave a brief overview of the two population based studies, *Preventable Hospitalizations in California* and *Racial and Ethnic Disparities in California*. These reports are derivative from the fact books that OSHPD has published in the past. They are tied in to the reports published by the Agency for Healthcare Research and Quality (AHRQ); the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR). The OSHPD reports are based on AHRQ Quality Indicators using OSHPD Patient Discharge Data.

Both of these OSHPD reports are descriptive statistical reports. They are not outcomes reports, nor are they policy reports. They represent OSHPD's effort to look at our data, using standard statistical tools that AHRQ has published, and see what it can tell us about certain domains. The two reports look at the same set of prevention quality indicators, but they are stratified in two different ways:

- PQI 1—Diabetes short term complication admission rate
- PQI 2—Perforated appendix admission rate
- PQI 3—Diabetes long term complication admission rate

- PQI 5—Chronic obstructive pulmonary disease admission rate
- PQI 7—Hypertension admission rate
- PQI 8—Congestive heart failure admission rate
- PQI 9—Low birth weight

- PQI 10—Dehydration admission rate
- PQI 11—Bacterial pneumonia admission rate
- PQI 12—Urinary tract infection admission rate
- PQI 13—Angina admission without procedure
- PQI 14—Uncontrolled diabetes admission rate
- PQI 15—Adult asthma admission rate
- PQI 16—Rate of lower-extremity amputation among patients with diabetes

The *Preventable Hospitalizations in California Report* looks at the 14 distinct ambulatory care sensitive conditions in terms of preventable hospitalizations. These are conditions which, if a patient was getting access to proper primary care, should never result in the need for hospitalization. So when people come to the hospital with these conditions, that is an indication that somewhere along the line there has been a failure in the healthcare system. The prevention quality indicators represent conditions that are acute, which could be anticipated or chronic which, if well managed, would avoid a hospitalization.

The *Racial and Ethnic Disparities in California Report* will help to examine the healthcare equity within the diverse California population and the disparities that exist in terms of resources and access to healthcare. The report will also gives insight into other questions; are there particular local burdens of disease and what healthcare needs exist in various communities within California.

In preparing this report, staff adjusted for what is known as prevalence, recognizing that the incidence of disease has some natural variation across groups. By making this adjustment, it becomes more evident if there is an actual disparity in access of care that is driving the outcome. In order to get these prevalence rates, staff used a compilation of statistical data that UCLA prepares, called the California Health Information Survey.

Closing Comments: Vito Genna, Chair

Chairperson Genna again welcomed the two new Commissioners and asked if they had any comments.

Commissioner Corless stated that “there is a lot of information to absorb, and learn, and understand, but I welcome the opportunity.”

Commissioner Karkia stated that as a new Commissioner he had taken the time to research the Commission to the extent that was possible, but that he did have some questions which he requested be stated in the minutes.

“Is this Commission being controlled by, say for example, any external bodies in any shape or form, or is it an independent body which advises the Director of OSHPD? I

don't know the road map, where we are and where would we like to be, and how this Commission can help OSHPD to facilitate the Governor's healthcare proposal."

"And to that end, Mr. Chair, respectfully, I am requesting you consider having a special session, which is outside the sessions listed, in which we can discuss where we are, where we are going and what are our limitations."

Chairperson Genna stated that, "There was some time back a two-day retreat where we did talk about direction. If we can resurface that information, that might be a starting point. Of course, these meetings are public and we do have some restrictions. As to the role the Commission plays, "Our role is very clear in that we advise the Director to go forward with certain recommendations and it is up to the Office to go forward or not."

Director Carlisle added, "That is correct. That really is the primary function of the Commission. And perhaps because it has been a while, since we have revisited this, maybe at an appropriate opportunity, at some point in the very near future, we should have a more detailed briefing for the Commissioners about the statutory definition of the Commission, its responsibilities, its authorities, and the relationship to the Office. This is something we could put on the agenda for a future meeting."

Commissioner Karkia stated that he would certainly appreciate that, adding "I was under the impression that when we meet as the California Policy and Data Advisory Commission, we would talk policy which can have a major long-term impact rather than short-term, step-by-step, tactical strategies. I am very grateful, Dr. Carlisle, for your staff, they have been most cooperative, and yourself." Commissioner Karkia explained that he has done his research and was not looking for a new Commissioner orientation, but a discussion of the long range plans of the Commission with respect to its advisory function to OSHPD. "Perhaps a booklet with the bylaws, and what the long-term strategy is can be put together and we can take it from there. Thank you."

Chairperson Genna asked if anyone would be opposed to having a meeting the day before or the day after a regular Commission meeting to go through some of those items.

Director Carlisle stated that it would require a public notification process and it would be a public meeting. Legal Counsel Herse added that "we would need to look at those issues because serving the policy intent of a body normally would be considered part of its policy function, which is normally public."

Commissioner Brien proposed that Chairperson Genna and Director Carlisle discuss the matter and come up with a date, propose that date to the Commissioners as to their availability and proceed from there.

Next Meeting: The next meeting will be held on June 9, 2008 in Long Beach, California.

Adjournment: The meeting adjourned at 12:23 p.m.

Pending Items:

1. Commissioner Greenfield recommended that the Commission requests that the Office should look at the addition of Percutaneous Coronary Intervention (PCI) to the outcomes being studied." No timeline stated.

2. Report to the Commission on the implications and feasibility of adding the "Identification of Transferring Facility" variable at the June meeting.

3. Report on summary of suggestions received regarding the data elements definitions.

4. Commissioner Karkia requests a special session of the CHPDAC to discuss various issues pertaining to the functions of the Commission.